these straitened financial times I am of the opinion that neither private health-insurance funds nor public health budgets should be used for dynamic psychotherapy. They should be used for the other, more effective treatments.

I consider that all psychological treatments should be evaluated as to their efficacy, safety, and cost, then registered, exactly as drug treatments are at present, before being provided by a health service. My position is, therefore, very similar to that proposed by Cochrane (1971), that no new treatments should be introduced into medicine unless they have been shown to be more effective, or as effective but safer and cheaper, than existing treatments. It is, therefore, important to use shrinking health-budgets to support the proven remedies to comfort, relieve, and cure the maximum number of patients, and not to use them to support a sectarian battle between the psychotherapies.

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**Treatment resistance in schizophrenia**

SIR: Despite major advances in our understanding of the neurobiology of schizophrenia, treatment resistance remains a challenge to the clinicians. Treatments using psychological principles have rarely been subjected to the rigours of controlled trials. Hence we read with interest Tarrier *et al*'s study (*Journal*, April 1993, **162,** 524–532). They reported a significant reduction in psychotic symptoms in drug-resistant schizophrenics treated with cognitive–behavioural methods. They also reported that, at six-month follow-up, five patients (22%) were in complete remission. The method is sound and the findings are highly impressive. However, a few issues are worth considering.

(a) The patient sample was drawn from community settings; it could be argued that they were well enough to be in the community and hence not representative of the truly resistant sample who usually remain in the hospital.

(b) There is a high drop-out and refusal rate. Out of the 48 suitable patients, only 56% continued to post-treatment and 48% to six-month follow-up. Of those who dropped out, two were incoherent and six were readmitted to hospital on account of violent behaviour or affective symptoms. Again, this would suggest that those who remained in the study were less intractable.

(c) Perhaps it would have been interesting to obtain some information about those who dropped out of the study, although we do appreciate the Herculean task involved in such an endeavour.

(d) It has been reported that positive symptoms showed substantial fluctuations despite the patients being on stable psycho-pharmacotherapeutic regimes (Johnston *et al*, *Journal*, January 1987, **150,** 60–64). Hence remission of psychotic symptoms in 22% of patients in this study should be viewed with caution.

(e) The authors mention that the patients were resistant to regular and stable neuroleptic medication, but unfortunately there is no mention of the groups of drugs tried, the dosage, duration, compliance, blood levels, and so on. The definition of drug resistance itself would otherwise be open to criticism.

(f) It would have been interesting to know whether the patients were on medication during the study period.

However, despite these finer points, this study offers hope from therapeutic nihilism and emphasises the need for conducting controlled trials of psychological treatments in schizophrenia.

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AUTHORS' REPLY: We were pleased to note Mirza *et al*'s positive comments about our recent report and we welcome this opportunity to respond to the points that they make, we will respond to these in the order that they are presented.